MONTANA MENTAL HEALTH NURSING CARE CENTER
EXPOSURE CONTROL PLAN
EMPLOYEE EXPOSURE TO BLOOD AND BODY FLUIDS FORM
********CONFIDENTIAL********

I have been informed of the possible dangers that may result from exposure to blood and body fluids.

I do <u>not</u> wish to see a physician ( ). **I do wish to see a physician ( ).**

_____
Employee Name (Please print):

_____
Employee Signature:

_____
Date:

_____
Witness Name (Please print):

_____
Witness Signature:

_____
Date: